

PRINTED: 02/19/2014  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN2601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  02/12/2014	
NAME OF PROVIDER OR SUPPLIER  SOUTHERN TENN MEDICAL CENTER SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 629 HOSPITAL ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  A Licensure survey and complaint investigation, #31724, were completed on February 12, 2014, at Southern Tennessee Medical Center SNF. No deficiencies were cited under Chapter 1200-08-06, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6599

L4F711

If continuation sheet 1 of 1